

## Referral and Intake

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### Introduction

The first step in providing care to children who have been victims of crime is the receipt of a referral. This chapter provides guidelines to assist mental health professionals in the completion of the referral and intake process. This task involves responding to referrals from a variety of sources and following procedures to assure appropriate service for child victims of crime and their families. Topics include the interaction with the referring party, the information-gathering process, and special considerations for the practitioner.

Each individual and family deserves respect with regard to their situation, cultural background, unique attributes, and belief systems. The best interest of the child is the most important guiding principle. The following guidelines are offered as a resource to assist those involved in receiving referrals and linking child victims to needed services. They are not designed as a checklist or road map that indicate the only proper route. To do so would minimize the psychosocial complexity of these situations.

### Guidelines for the Referral Process

Private practice clinicians and intake workers in agencies should be trained to manage most intake calls; even those not directly appropriate for one's own services. Every effort should be made to ensure that the caller is responded to in a timely and efficient manner. The initial contact is critical in affecting the caller's future involvement in therapy. The primary purposes of the intake call are to gather the information necessary to ensure the safety of the child, and to offer the most appropriate and accessible mental health treatment possible to both the child and family.

A caller's initial contact should provide the opportunity to connect with and feel supported by a competent helping professional. This individual must be flexible and possess the ability to react swiftly and appropriately during crisis situations in order to promote the safety of the child and family. The intake staff should be able to assess emergency situations. For example, if a caller describes behaviors that include suicidal ideation or gestures, a referral to the local emergency room or phone numbers for local psychiatric evaluation and response teams should be offered to the caller immediately.

The mental health clinician should maintain a supportive professional role toward potential referral sources and clients. It is important to maintain clear professional boundaries while conversing with a referring source. During the initial phone contact, the caller may sound distressed. The practitioner should respond in a supportive manner, but therapy intervention should not occur until formal treatment begins. Information received during the intake should trigger an appropriate triage process. It is the practitioner's role to assess the needs of the caller and determine whether these needs fit within the practitioner's scope of practice. The practitioner must be qualified to address the specific presenting problem. For example, a mother may call requesting treatment for her adolescent son who has recently molested a younger child. The clinician should agree to see the boy only if he or she has had the appropriate training and experience in treating adolescent offenders.

The clinician should gather the information necessary to establish whether there is reasonable cause to make a child abuse report. Clinicians have an ethical and legal obligation to comply with the Child Abuse Reporting Law and to remain current on its requirements. The caller can be informed of this obligation and that a report will be made, when necessary. However, the clinician should act in the best interest of the child, which may involve deciding not to inform the caller or the child's family of the intention to report if this

action could place the child in danger. For more information, see the chapters on “Ethics” and “Legal Issues.”

## **Refusal of Referrals**

Various factors must be considered to ensure the most appropriate treatment for the child and family. These factors include geographic proximity, level of care available and expertise to treat a specific population. In some cases the caller may not be best served by the particular agency or practitioner contacted. Transportation options should be considered. If transportation is a problem for the family, the client should be referred to an agency or practitioner close to the child’s home. It may be necessary to offer referrals to agencies that are more conveniently accessed through the family’s own ethnic community. Referral options can be offered, and the parent or caregiver can choose the agency or practitioner that best suits the needs of the child and family.

Depending on the specific presenting problem(s), appropriate treatment can involve levels of care ranging from outpatient individual therapy to inpatient treatment. Treatment can involve only the victim, but more often the victim is best served when other family members are offered collateral treatment as well. Based on the specific needs of a family, the intake worker may recommend their own agency or refer out to another agency for primary or ancillary services. Finally, the caller should be offered services that have foundations in research and training. The child or family should be seen by a practitioner who has specific expertise in the treatment of trauma in children.

A mental health practitioner may receive referrals from a number of different sources. These referral sources have varying levels of experience in identifying child abuse and in making referrals for mental health services. The practitioner is cautioned to be certain that the presenting need of the client can be addressed by therapy. For example, it is not appropriate to refer a child for mental health services for the sole purpose of obtaining a disclosure regarding suspected abuse. However, it may be appropriate to refer for therapy when abuse is suspected, if the child exhibits emotional or behavioral difficulties that can be alleviated by therapeutic intervention.

The following section addresses the role of the mental health practitioner in gathering important and relevant information from specific primary referents. Many individuals may contact a clinician or agency seeking treatment for a child. However, the practitioner must be sure that the referent has the authority to make a referral on behalf of the child or parent. The clinician is legally and ethically permitted to gather information and formulate plans for treatment only with an individual who has custody or holds privilege for that child. In the event that other individuals call (such as social workers, attorneys, teachers, clergy, physicians, or interested others), the practitioner should recommend that the client’s primary caregiver contact the agency or practitioner directly. For more information, see the chapters on “Ethical Issues” and “Legal Issues.”

## **Referral Sources**

### **Parents or Caregivers**

It is often the case that a parent will call a practitioner or agency seeking therapeutic services for their child following victimization. Parents will often notice changes in their child’s behavior following disclosure of abuse or after other crimes against the child. It may also be the case that a parent would like a therapist to help clarify whether the child has, in fact, been victimized. Finally, treatment may be court ordered. Once again, it is important for the therapist to clarify the type of services he or she or the agency can provide. The therapist should not undertake the investigative role in responding to a crime; forensic interviews should be conducted only by those specifically trained to do so.

It is also important for the mental health practitioner to offer support to the parent. Brief educational information about the therapeutic process, including the involvement of systems such as medical, legal, protective services and law enforcement, can offer parents an opportunity to prepare themselves and their

child for what may follow. Parents should be treated as individuals with the right to assert their own perceptions and needs about the type and setting for therapeutic services. The practitioner can offer referrals to the parents for their own therapy as well as for relevant support groups. Haskett et al. (1991) assert that allowing non-offending parents greater decision-making power and responsibility in the referral process can result in greater attendance and compliance during treatment. Self help support groups may also serve to improve attendance rates by increasing social support and decreasing the stigma often associated with psychotherapy. The mental health practitioner can be an important source of information for parents making their first call regarding a crime against their child.

### **Public Child Welfare Agencies**

Child Welfare Workers (CWW) — also called Child Protective Services Workers or Children’s Social Workers — often refer children and families to mental health professionals for counseling. The referrals may be court ordered or initiated by the CWW who recognizes the need for such services. Ideally, all children removed from their homes due to abuse or neglect should be referred for mental health services in a timely manner.

When contacted by a CWW, the mental health practitioner should assess whether his or her services are most appropriate for that child. The practitioner should gather necessary information including: relevant history, history of placements, current placement, court proceedings, visitation plans, court orders for treatment, previous evaluations, and any progress reports or evaluations they are expected to complete. This information will clarify the role of the practitioner and the expectations of the CWW. An ongoing consultative and collaborative relationship with the child’s CWW can be an essential component of a successful therapeutic process. This relationship begins with the first phone call and can be fostered through ongoing contact and, when appropriate, gathering information to advocate for the best interest of the child. See the “Public Child Welfare” chapter.

### **Legal System**

An attorney representing the interest of, or holding the privilege for a client may call an agency or practitioner in order to initiate the referral process. The particular stage of legal proceedings can be a key factor in the clinician’s decision to accept or refuse the referral. For example, if a victim is presenting with hesitant or inconsistent disclosures regarding a crime, the attorney may be attempting inappropriately to use the therapist as an extension of the legal discovery process. Such a role is not acceptable. Clinicians should remind attorneys of the difference between forensic evaluation and clinical work.

Another possible scenario involves a child who is a dependent of the Court due to victimization within their family. In this situation, the attorney may be seeking treatment in order for the practitioner to assess and recommend appropriate visitation or reunification plans. Again, the role distinctions should be discussed with the attorney. Ideally, the primary evaluator (who recommends custody, reunification or visitation) should not be the child’s therapist.

Finally, an attorney may seek treatment on behalf of a client who has already completed the court process and is in need of therapeutic services to address their emotional needs. This is an appropriate role for the clinician. In this situation, the clinician should continue to document clinically and legally relevant material.

Regardless of the point within the legal process at which a potential client contacts the clinician, it is important for practitioners to clarify whether they can fulfill the expectations of the attorney. For example, if the attorney expects the clinician to testify in the future, the clinician should clarify at the outset whether he or she is willing to testify in the role of an expert or a fact witness. This distinction is clarified in the “Ethical Issues” chapter, and may affect the attorney’s decision to seek therapeutic services through the particular clinician or agency. It is not in the best interest of the client, practitioner, or referring party to offer treatment that is in conflict with the specific requests made by the referent without informing the client or parent of potential conflicts. This matter is covered below in the Court Orders for Treatment section. The practitioner should make the professional disclosures and clarifications necessary in order to allow the referent the opportunity to make the most informed decision possible in considering the best interest of their client.

## **Physicians**

Physician referrals for mental health services may be initiated from private physician offices, Suspected Child Abuse and Neglect (SCAN) clinics, or hospitals. While processing the referral, clarification should be made with the referring physician regarding the purpose of the referral, and the expectations that the physician may place upon the mental health practitioner. Types of referrals can include:

- Patients with significant findings that suggest abuse (with or without disclosures of abuse)
- Patients with disclosures but no specific physical findings
- Patients presenting with behavior changes or other psychosocial issues (with or without physical findings)
- Children caught in custody battles
- Other dysfunctional family situations

Depending on the nature of the referral, the physician may be requesting either counseling or assistance in obtaining a disclosure. At times, if the child has no immediate mental health needs, a specific referral to a forensic evaluation center may be indicated. Some physicians encourage maintaining an ongoing relationship with the practitioner for updates and input on the child's progress. Some data from the physician's medical records may be pertinent to the therapeutic process (for example, whether or not there are significant physical findings resulting from the crime). Mental health practitioners can request information they feel is necessary to positively impact the treatment plan. The practitioner is encouraged to develop and maintain a good working relationship with the medical team to maximize inter-disciplinary cooperation.

## **Multidisciplinary Intervention Centers**

Some programs are referred to as Multidisciplinary Intervention Centers (MDIC). This team approach often includes the services of medical staff, social workers, psychologists, and law enforcement personnel. Multidisciplinary teams exchange necessary information among members to investigate criminal allegations and to promote the most appropriate treatment of the child and family. The laws and ethics pertaining to MDIC teams are beyond the scope of this discussion. Mental health providers should not participate as MDIC team members or forensic interviewers without specialized training and knowledge of the legal and ethical issues involved.

According to Britton (1998), health care providers have become particularly sensitive to the potential for re-traumatization of the child during forensic medical examinations. In response, steps are taken to provide the child with a greater sense of control. General stress reduction techniques including distraction and relaxation exercises, as well as preparation and debriefing, can be used to decrease the potential for re-victimization. The child may ask that the practitioner be present during the exam. The practitioner should assess potential legal issues, as well as dual relationship issues, when deciding whether to be present. Based on this assessment, the practitioner can choose to remain present and refer the child to another clinician for mental health treatment as necessary or to remain present in a way that is therapeutic for the child and appropriate to the therapeutic relationship.

## **Teachers**

Children often disclose abuse to a trusted adult outside of their family, such as a teacher. McGurk et al. (1993) discuss twenty adolescent sexual abuse victims who disclosed their abuse to school personnel when inquiries were made regarding the presence of any such history. Of the twenty adolescents, only two had disclosed the abuse while it was ongoing. In the remaining eighteen cases, an average of six years had passed since the last abusive event, with half of the cases having no prior disclosure.

In addition to actual inquiries made through school programs, abuse prevention presentations are often made in school classrooms. Following these presentations and discussions, increased awareness and changed motivation can lead children to disclose abuse.

Upon receiving a call from a teacher, the status of the child abuse report should be addressed. Has the teacher, as a mandated reporter, already filed a child abuse report? If not, they should be encouraged to do so to ensure the safety of the identified child as well as other potential child victims and the practitioner can request a faxed copy of this report to ensure a report has been made. The therapist should also clarify the reason for the teacher rather than the parent making the call, and explore if the parents are aware of the report. After obtaining consent for release of confidential material, important information about a child can be obtained from a teacher.

### **Self-Referrals By Minors**

Parents are often the most common self-referral source. However other individuals including the child or adolescent, friends, neighbors, relatives, and others may make self-referrals. In the case where a child or adolescent self-refers, appropriate legal guidelines must be followed. A child twelve years of age or older is able to consent for his or her own outpatient mental health treatment in a number of cases, including child abuse and rape (see chapter on “Legal Issues”). In other words, a child age twelve or over that has been abused does not need permission from a parent to be seen for outpatient mental health treatment. The intake worker should be aware of the particular cases that do not require consent by a parent. If the parent’s consent is required, the intake worker or clinician should explain this to the child and encourage the inclusion of the parent as appropriate to ensure provision of necessary services to the child.

In terms of self-referral in general, many of the guidelines in this chapter apply, including child abuse reporting requirements and important information gathering issues. The referent may ask to be kept anonymous or refuse to make a report. In this case, the clinician should make all appropriate efforts to gather the information necessary to assess reasonable suspicion and to ultimately promote the safety of the child.

### **Victim Witness Advocacy Centers**

When individuals have been victimized, they may seek information and financial support through their local victim witness advocacy center. Although many child treatment agencies directly aid families in completing Victim of Crime applications, some counties depend upon victim advocacy centers for this service and other court advocacy needs. For example, victim witness centers can submit claims to the Victims of Crime Program for funds to cover funeral and burial expenses, transportation, lost wages, medical treatment, and mental health treatment. The victim advocate has a list of potential agencies and private practitioners that they consult in order to offer the victim(s) an appropriate referral. The advocate may call the agency or practitioner to initiate the referral or offer the victim a list of potential referrals. In either case, it is helpful for the practitioner to know that the application has been submitted and that the victim has accessed assistance through a victim advocate. After obtaining a copy of a signed release of information, the clinician receiving the referral may choose to gather information from the advocate with regard to the police report, details of the crime, and the status of the VOC claim.

### **Law Enforcement Personnel**

Law enforcement personnel, including police, sheriff, and probation personnel, make referrals to mental health professionals for a number of reasons. While their primary responsibility is to investigate crimes for the purpose of arrest and prosecution, they often recognize the need for mental health services for the victims they serve.

Occasionally, law enforcement initiates a referral in the hopes that a victim will disclose details of the crime during the course of therapy, or that additional pertinent information will be obtained. As a result, the role of the mental health practitioner can vary depending upon the situation. Therefore, it is important that the

practitioner remain clear as to the expectations of law enforcement and whether or not these expectations can be fulfilled within the practitioner's scope of practice and ongoing treatment plan.

### **Interagency Referrals**

It is often the case that one agency will refer to another in order to access treatment for a victim. An agency may not be able to provide treatment due to geographic location, funding resources, or lack of staffing or expertise. A study by Humphreys (1995) focused on the characteristics of the agency environment that may either facilitate or preclude therapy attendance. These researchers offered a variety of situations, which lead to "dropout" among those who have been referred to an agency. These include the actual screening procedures used when the referent makes first contact with the agency. Unless there is some formal procedure that can be tracked, the information can be lost and in effect the family is left with no service. Parents reported that the waiting time for counseling was a major problem, which resulted in their feeling "dumped" and forced to cope alone. Mental health practitioners should be aware of agency procedures as well as the limitations of their own agency's referral process in order to assure that the family is offered timely and comprehensive care.

Referrals may also be made within an agency. For example, in a hospital setting, a child may be seen by the medical staff for injuries that have been sustained as a result of abuse. The medical or social work staff may then contact a mental health program within the hospital to refer for assessment or treatment.

Potential conflicts of interest can surface within agencies where both forensic investigative interviews and treatment are conducted. Those in opposition to this practice raise concerns that the treatment program has the potential to benefit financially from referrals from the forensic investigative program, thus risking bias in the identification of victims. Agencies that employ such a referral process within their establishment should keep these potential conflicts in mind when interacting and intervening with child victims of crime and their families.

### **Information-Gathering Process**

The actual intake or screening is a crucial step in the helping process. A thorough gathering of relevant information provides the mental health practitioner with demographic information regarding the child, family, and other relevant individuals involved in the case (social worker, detective, attorney, victim witness advocate), financial status, school information, description of the crime, relevant background and history of the presenting problem, and presence and severity of behavioral symptoms.

### **Nature & History of Allegations**

The nature and the history of the current allegation as well as any prior allegations are important information. These inquiries allow the clinician to become aware of the specifics of the alleged crime, including when it happened, where, duration, frequency, and severity. This information allows the clinician the opportunity to assess the family circumstances and coping skills, as well as the relationship of the child's symptoms to the most recent crime.

### **History of Symptoms**

The clinician should inquire as to current symptoms displayed by the child and how long these symptoms have been present. For a more comprehensive explanation of gathering relevant history of symptomatology, please refer to the "Assessment" chapter.

### **Financial Data**

It is important to evaluate the client's financial circumstances to consider all possible resources when developing an intervention plan. For example, does the client have the ability to pay for services, or treatment funding through private insurance or Medi-Cal? Is the clinician or agency an approved provider for the client's medical plan? Is there a sliding scale program available for clients with financial need?



Since the Victims of Crime program is the payor of last resort for crime related expenses incurred by the client, the clinician must be aware of other reimbursement sources available to the client. The therapeutic process should not be initiated until financial issues are clarified. This step is important in order to avoid the necessity to refer a client who is unable to pay after a treatment alliance has been developed. Many agencies assist families with completion of Victim of Crime applications as part of the intake process, or coordinate this process with the local Victim Witness Advocate's office, thus improving access to services.

### **Court Orders for Treatment**

A court order can clarify specific treatment modalities and duration expected in order to fulfill court recommendations. It can also offer insight into the client's motivation for calling and their continuing commitment to the therapeutic process. A clinician should review court orders in order to assess the clinical validity of the court's treatment plan. If the practitioner disagrees or has concerns regarding the recommended type, frequency, or time limit of therapy, a request can be made to evaluate the child and to offer recommendations for an alternative treatment plan. The clinician can make recommendations to the court through the child's attorney or the Child Welfare Worker. Mental health professionals should never attempt to contact judges directly because communication with the court follows a formal legal process. If the court does not revise the court orders, the clinician should inform the caregiver that a conflict exists and offer either to provide services that do not conform with the court orders or to refer to other clinicians who are willing to cooperate with the court's plan. The Child Welfare Worker can usually assist with such referrals. For example, if family therapy has been ordered but the agency does not provide therapy in this modality, the family should be referred to an appropriate agency that does provide this service.

### **Physical Evidence**

The clinician should obtain information from the caller as to whether the alleged victim has had a medical examination. If the child might have been injured (such as in any case of alleged physical or sexual abuse), the child should be referred for medical evaluation. In many cases, a forensic medical examination is necessary to gather evidence of a crime and assess the child's medical condition. Typically, law enforcement determines when a forensic medical examination is required and directs the family to a qualified examiner. If a medical examination has already occurred, the clinician may inquire as to any physical findings of injury and may obtain the medical report with appropriate consent from the parent. For information on accessing confidential medical records, see the "Legal Issues" chapter.

### **Additional Information-Gathering**

Proper documentation, including releases of information and consent forms, should be explained to and endorsed by the client or the client's legal holder of privilege before any additional clinical information regarding the patient is gathered. Important information that is relevant to the treatment process can include the police report, medical reports, school records, and a court order if one exists. When corresponding by mail, fax, or e-mail, after obtaining permission from the client or custodial parent to do so, the clinician should ensure that the information is delivered in a secure and confidential environment. If this is not possible, the clinician should ensure the removal of identifying information from the documents.

### **Conclusion**

This chapter has presented information regarding referral and intake for child victims of crime. Important aspects of the intake process were presented, including clarification of the role of the mental health clinician when gathering information from a variety of potential referral sources; guidelines as to what information to gather; and the effects of the intake process on the child and family. The major issues highlighted in this chapter emphasize the clinician's role in assessing their own expertise and skill, identifying and requesting appropriate collateral information, and offering the most comprehensive and appropriate service to the child and family. During all stages of the therapeutic process, the practitioner's actions should ensure the best interests of the child as well as provision of the most appropriate therapeutic care.

